TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pain & Recovery Clinic – North

Respondent Name
Seabright Insurance Company

MFDR Tracking Number
M4-15-3326-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: $1088.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerning charges for work hardening under CPT 97446-WH for service dates 7/9/14, 7/10/14, 7/11/14, 7/14/14, 7/15/14 & 7/16/14. For each date, Requestor billed $230.40 and Carrier issued reimbursement of $51.20. No additional reimbursement is owed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9 – 16, 2014	Work Hardening (97546 WH)	$1088.00	$934.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 320 – Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
   - 224 – Duplicate charge.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are regarding CPT Code 97546-WH subject to the fee schedule found in 28 Texas Administrative Code §134.204 (h), which states, in relevant part, "The following shall be applied to … Work Hardening/Comprehensive Occupational Rehabilitation Programs … (1) Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier 'CA' shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR … (3) … (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier 'WH.' Each additional hour shall be billed using CPT Code 97546 with modifier 'WH.' … (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments…"

   Review of the submitted documentation supports that a total of six hours were documented for each date of service in dispute – July 9, 10, 11, 14, 15, and 16, 2014. Because the initial two hours under CPT Code 97545 is not in dispute, only the remaining four hours will be considered. Four hours multiplied by the reimbursement rate of $64.00 is $256.00. Documentation does not support that the requested services are part of a CARF accredited program. Therefore, the allowable reimbursement is calculated at 80 percent of MAR, which is $204.80 for each date.

2. The total allowable for the disputed services is $1228.80. The insurance carrier paid $294.40. Therefore, an additional reimbursement of $934.40 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $934.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $934.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 15, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.